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FAMILY MENTAL HEALTH PAPERS

Presented to

Family Social Worker Personnel

of the

LOS ANGELES COUNTY
BUREAU of PUBLIC ASSISTANCE

Department of Charities

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Bureau of Public Assistance

FAMILY MENTAL HEALTH

Papers Presented in General Session of
Training Course for Staff

of

Bureau of Public Assistance

January 8 and 9, 1964

Jean McDermott, Assistant

Los Angeles

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Los Angeles County
Bureau of Public Assistance

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Training Course for Staff
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January 8 and 9, 1964

Jean Delacour Auditorium

Los Angeles

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FOREWORD

Most social welfare staff employed by local public assistance agencies start on the job without the knowledge and skill demanded by their positions. In this past year alone the Los Angeles County Bureau of Public Assistance hired almost one thousand case workers who had little or no previous social work training. This number is more than a third of the number of graduates of all schools of social work in this country in 1962-63. It is now quite evident that public welfare agencies can rely on graduate school trained social workers for staffing only a very small part of the public social service program. This places a heavy responsibility on the public assistance agency to provide initial and ongoing staff development. Numbers of resources must be utilized in providing appropriate training. This publication presents one part of the staff development program in the Los Angeles County Bureau of Public Assistance. It represents a united attempt by several agencies to help the family public assistance worker gain clearer insight into family mental health and his role. The Bureau of Public Assistance is deeply indebted to Mrs. Frances Lomas Feldman who voluntarily chaired this training endeavor. We wish to thank those agencies and their representatives who so willingly assisted in both the formulation and the mechanics of this staff development program.

Ellis P. Murphy, Director
Los Angeles County Bureau
of Public Assistance

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CONTENTS

Foreword

Ellis P. Murphy-----p. iii

Introduction: Mental Health and Public Welfare

Frances Lomas Feldman-----p. 1

The Normal Family

Dr. Talcott Parsons-----p. 9

The Unique Opportunities of Public Assistance Workers to Help Families in Crisis

Dr. Alexander Rogawski-----p.29

Meeting the Social Needs of a Family Receiving Public Assistance

Frances H. Scherz-----p.52

Appendix A: Some Questions and Answers-----p.75

Appendix B: Program-----p.78

Appendix C: Workshop Leaders and Resource Experts-----p.79

INTRODUCTION: MENTAL HEALTH AND PUBLIC WELFARE

Frances Lomas Feldman

No helping group has been more affected than the public assistance workers by society's attitudes toward the troubled poor and the community's arrangements for endeavoring to relieve the symptoms, if not the causes, of their troubles or poverty. The expanding scope and depth of programs of public assistance increasingly have been directed toward helping families and individuals to achieve as effective a level of social functioning as is possible for them, given their different constellations of intellectual endowment, personality structure and development, opportunities, and qualities that facilitate or impede their utilization of such opportunities as may exist. Although the trend of public policy for some time has been to emphasize the importance of strengthening the family and assisting recipients of assistance to move toward self-support or self-care, the 1962 Amendments to the Social Security Act have added a compelling note in defining the nature and quality of services to be provided, and in the terms of correlative financing arrangements.

These amendments have encouraged public assistance agencies to reduce the size of family caseloads and to take other action that maximize the workers' opportunities to identify the problems that lead to continued dependency, and to take appropriate steps to aid the recipient in dealing with these problems. A consequence of these measures has been

to reveal even more sharply what had long been known: the need for income maintenance may have precipitated the family's turning to the public welfare agency for aid, but in a large number of instances the economic need was either the cause or the result of mental health problems of at least a key figure in the household. Moreover, as the social insurances have more and more provided at least partial replacement of income from wages, and families suffering loss of earnings of a breadwinner in covered industry have had to rely less on public assistance to meet their survival needs, a higher proportion of those turning to public assistance comprises families with severe problems that either have kept them out of the labor force or interfere with their current and future functioning as contributing and self-sustaining members of our society.

In 1960, the Mental Health Survey of Los Angeles County took cognizance of the many more or less severely disturbed individuals and families whom public assistance personnel were endeavoring to help. It noted, too, some of the obstacles faced by this personnel in utilizing community mental health services in the treatment of recipients identified as disturbed. It was evident that a large majority of the workers in direct contact with families containing one or more emotionally or mentally troubled or retarded persons lacked a background of professional education, yet were expected by the agency and the tax-paying community to achieve constructive results with persons often so disturbed that psychiatric resources viewed them as not amenable to help.

When the Welfare Planning Council's Mental Health Development Program was established with funds from the National Institute of Mental

Health to implement certain of the recommendations of the Mental Health Survey of Los Angeles and to strengthen community planning for mental health, a Committee on Mental Health and Public Welfare was formed. Its primary activity was directed toward meeting the request of the Director of the Bureau of Public Assistance--Mr. Ellis P. Murphy--for consideration of ways in which the psychiatric community could be of help to the Bureau in effectively fulfilling its obligations for social services.

A PROJECT IS CREATED

As its first step, the Committee on Mental Health and Public Welfare undertook to develop a pilot training program in mental health concepts. Its objectives were several: to help public assistance staff through acquisition of knowledge about mental illness and mental retardation and mental health to 1) assess the meaning of behavior they encounter; 2) take appropriate steps in providing help for dealing with emotional or mental **disturbances**; 3) use with greater sophistication consultative and other resources concerned with mental illness; and 4) perform their most difficult job with increased satisfaction for themselves, with increased sophistication for the benefit of their clients--and with awareness that there are different ways of meeting psycho-social needs and different expectations as to what constitutes successful achievement in work with public assistance recipients.

The papers that follow were presented in the first phase of a three-phased training program. The three papers were given on each of two consecutive days in order to reach, with a minimum of disruption of work schedules, a substantial proportion of the workers and supervisors

serving families in the Aid to Families with Dependent Children program in Los Angeles County. The presentation of each paper was followed by a period in which questions could be posed--verbally or in written form--to the speaker. The papers were to serve as a background for series of discussion sessions in which each worker and supervisor would participate.

THE GENERAL SESSIONS

Each of the duplicated days of general sessions was divided into three segments (see Appendix B). Because a goal of the public assistance agency is to enable a family to function as a "normal" family, Dr. Talcott Parsons was asked to discuss "The Normal Family," its expectations of society, society's expectations of the family, and the roles and inter-relationships of family members. Against his picture of the family in our changing society, the public assistance worker could consider whether the attitudes and behavior of a recipient family--or of the agency about the family--are conforming or deviant.

The second segment focussed upon the family and crisis, and Dr. Alexander Rogawski dealt with what the public assistance worker brings to the client-worker relationship that facilitates helpful intervention in crisis situations.

To Mrs. Frances Scherz was assigned the task of describing and analyzing ways in which public assistance staff can effectively meet social needs within the framework of the public assistance structure.

The papers are reproduced here as presented by the authors, with only that minimum editing required to make readable the work prepared as

listenable. Although the questions, and the responses, were taped, only a few are incorporated in these proceedings--primarily for the purpose of illustrating for the reader the kind and quality of the interchange between the speakers and the audience.

THE DISCUSSION SERIES

Preparation. It was the conviction of the Committee on Mental Health and Public Welfare that the transferability of the content of the three papers to the day-by-day work in the public assistance setting required that the public assistance staff be afforded opportunity to discuss, consider, question, and consolidate the available learnings. Furthermore, to large measure, the effectiveness of such opportunity would depend upon the accessibility to the discussants of leaders possessing certain kinds of competence: they should be particularly knowledgeable about the philosophy of public assistance and the legal and psychological scope, demands, and limits of the public assistance agency on the tasks to be performed by public assistance workers; they also should be expert in knowledge about direct work with problems of mental illness or retardation and about community resources that might be called upon for direct service or planning or consultation.

The Bureau of Public Assistance made available ten training supervisors, all with graduate social work education; the California Department of Mental Hygiene provided fourteen psychiatric casework specialists and supervisors, also all holders of social work degrees. The Los Angeles County Department of Mental Health financed the services

of Dr. Eva Schindler-Rainman who, with the chairman of the Committee on Mental Health and Public Welfare, met for a day and a half with this group for the purpose of specifically orienting the members to working with each other, obtaining a common base of knowledge about program philosophy and policy, and a common framework of the teaching points and goals for the discussion sessions, as well as sharpening their skill in productive conduct of the discussion meetings.

Teaching aids were provided in the form of a list of suggested reading, brief case illustrations, and questions--the latter either having been submitted earlier by supervisory personnel along with the case examples, or raised and not fully discussed at the general sessions.

Discussion Groups. Each worker and supervisor who attended the general sessions subsequently participated in a series of four workshops of two hours each. These were spaced at weekly intervals, beginning within two weeks after the general sessions. Each of the groups contained a maximum of thirty persons, with supervisors meeting separately from those in worker classifications. Each series of four sessions was staffed by a training supervisor from the Bureau of Public Assistance and a resource expert from the State Department of Mental Hygiene.

THE ACHIEVEMENTS

A concurrent activity of the Committee on Mental Health and Public Welfare was an extensive and intensive research project designed to assess the efficacy of this training method and its effect upon attitudes and performance of public assistance personnel. This research, under the

direction of Dr. Maurice Hamovitch and Mrs. Mary Novick, will be reported in a separate publication in the fall of 1964.

Of particular significance is the demonstration of cooperation among various agencies interested in the importance of the public assistance service in our society, and in the essential nature of incorporating mental health concepts into the constructive advancement of this service. Thus, the County of Los Angeles Civil Service Commission and Bureau of Public Assistance contributed staff time and services to expedite the project; the State Department of Social Welfare provided a grant of funds to the Bureau of Public Assistance, which also contributed funds, to bring the out-of-state speakers to the general sessions and to prepare these proceedings; funds for the research project and for certain consultative services were provided by the State Department of Social Welfare, the County Department of Mental Health, the Bureau of Public Assistance, the Welfare Planning Council's Mental Health Development Program; many hours of professional staff time were contributed by the State Department of Mental Hygiene and the Bureau of Public Assistance in the conduct of the work-shops; and each of the agencies represented on the Committee contributed substantially in staff time and services.

ACKNOWLEDGMENTS

The Committee's special appreciation goes to Elsie Muslin and Marvin Freedman for the tremendous achievement, smoothly executed, of arranging not only many of the details of the two days of large general meetings, but also scheduling and coordinating twenty-five separate series of four

workshop sessions, each containing thirty participants. Richard Middlebrook and Ruth Short recruited the highly competent resource experts from the State Department of Mental Hygiene; Richard Raymond provided special service in taping the meetings and handling other such vital details; Dr. Mark Doran and Ralph Goff were especially instrumental in procuring the necessary financing for the project; Cerna Hirsch and Robert Jones shared the skillful task of providing the Committee with staff services.

But particular note should be made of the interest and service of Ellis P. Murphy, whose conviction about the vital nature to the agency and the community of the public assistance personnel's work, and the importance of providing this staff with tools to perform their tasks with satisfaction to themselves as well as to the agency and its clientele and supporting community, gave direction and enthusiasm to the Committee on Mental Health and Public Welfare.

THE NORMAL FAMILY

Talcott Parsons

It is something of an assignment to say much that might be significant about the normal American family in brief compass and yet will be significant for a group who have it as their jobs to deal very largely with families in trouble who do not quite fit the "normal" type. The very salience of the kinds of problems that concern you contribute very much to an impression that there has been a general process of family breakdown in modern society generally, and in this country in particular. I think, however, that the broad evidence does not bear that out, and I would like first to review some of that evidence and then to say a little something about both the importance of the family in the society at large and the very broad type which seems to be in process of becoming more standard.

OUR CHANGING SOCIETY

This is a society, we all know, which has been involved in a very rapid and extensive process of change throughout its independent national history, and perhaps one could say never more so than in our own time. For example, there has been a continuous process of differentiation and complication in its structure along with the growth in size of population following, of course, the enormous territorial accessions, but also a general process of the upgrading of both expectations and responsibility,

necessitating and involved with a related development of new modes of integration of persons and sub-structures in the increasingly complex society and with each other. It is, of course, a process which has also been complicated by external disturbances — two major wars in this century in which this nation has been involved, and the cold war of recent years. Therefore, it is a situation fraught with anxiety and conflict on many different levels. Though the family is in one sense such an immediately biologically grounded unit, and is also so small scale and therefore apparently simple, it has been just about as much caught up in the general process of change as any other part of the society, and the end of its changes and of the others certainly is not yet in sight, or anything like it.

I would like to suggest that the best single reference point for the change in the family is its differentiation in the sense that the nuclear family, consisting of parents and their own children, has become increasingly sharply differentiated from all other kinship units and from some kinds of non-kin elements with which they have been associated, as a unit of structure, but also in function. Its core functions of the maintenance of the household and the intimate personal relations of the members of the household have become increasingly differentiated from other functions. We are all, of course, aware of the immensely rapid urbanization of our society, which is associated with the fact that a rapidly decreasing proportion of the population live in units that are both residential and household units in our sense, and operative, producing units in the economy; the typical family farm has, of course, always been both. We still have the small

retail store, a few artisan or handicraft units, but the proportion of the labor force engaged in that type of unit has gone down, down, down until it is much the smallest in our history, and will go down further.

Family Composition. With this background, I will suggest a few figures about the most recent trend that I think brings out rather sharply the direction it has taken. If you examine the data on household composition, households with complete nuclear family -- husband, wife and their own children -- in 1940 constituted 80 per cent of the total number of households; by 1960 it had gone to 82.7 per cent, a definite increase. During the same period, household members who were relatives of the head of the household other than spouse or own children, decreased from 7.7 per cent to 5.5 per cent. The relatives are being extruded. Non-family members, that is, lodgers and living-in domestic servant, and even in 1940 only 0.8 per cent -- less than 1 per cent -- of household members were living-in domestic servants; but in twenty years that figure went down to .2 per cent, cut to one-fourth of what it was only twenty years previously. The living-in domestic servant has practically disappeared from an affluent society, which is a very interesting phenomenon. Of course there is the other side of the picture; the number of non-family households has increased greatly -- households composed of people living alone, or two or more people who are not related as family members to each other.

Divorces. A very interesting point is that in twenty years the proportions of husbands and wives living together, that is the proportion of total household members, has increased from 40.4 per cent to

44.1 per cent. There is nearly a 10 per cent increase in the proportion of household members who are husbands and wives living together, in spite of the maintenance of high divorce rates. As you know, the divorce rate remains high, but since the post-war peak has begun to decline slowly. I think it is correct to say that we now have the largest proportion of persons of marriageable age, not widowed, living with their spouses and their own children, if any, that there has been in the history of the United States census. This does not look like the dissolution of the family.

Births. With respect to birth rates, we know there was a population jump in about 1940, which has now been sustained for approximately twenty-five years, far too long to be explained by temporary re-employment or other factors of that sort in relation to the much lower rates of the 1930's. The net reproduction rate as of 1959 was a little over 1.7 per cent, which is a quite rapid rate of natural increase. There have been other very interesting and crucial changes. Though the process has slowed down, the average expectancy of life during the present century has increased very greatly. It is now approximately 70 years. The biblical three score years and ten, at the time this was written in the Bible, surely was reached by only a small minority of those born alive. Now it is almost exactly the average with, as you know, a very definite advantage of women over men; they have a 6.5 year higher expectancy than men, so theirs is substantially above 70 at birth. Another very interesting trend is the compression of the child-bearing period and its spacing in the early period of life. People live longer, but they have their children earlier, and though they have more children

than in their parents' generation, they have them closer together. So you have a very striking figure: the average American mother has her last child -- last child -- when she is at the age of 26. She is through with child-bearing, and she expects to live, on the average, to be well over 70, so there is a long time to live with other things to do than taking care of young children.

It follows that the average couple in the stage of the empty nest, as it is sometimes called, when the youngest child has left the parental home and become independent, now comprises at least a third of the total period of marriage and is increasing: before very long it will probably be a half of the period of marriage. Of course the combination of earlier marriage for girls -- the marriage age for girls has dropped to an average of 20, whereas the average for the boys is at 22 approximately -- and the greater longevity of women, means that in the nature of the case there will be a considerable excess of widows over widowers.

Education. Another very important process of differentiation of the life cycle has been the enormous growth of formal education. As you are probably aware, the whole population, with negligible exceptions, goes to high school. The proportion graduating from high school is well up in the eighties, the drop-out group constituting a very serious problem that is much involved with your function, I know. And about 40 per cent now go on to some kind of college, and the numbers graduating from a four-year college is more than 20 per cent and rapidly increasing. Finally, it is well known that by far the most rapidly increasing sector of the whole educational system is that of post-graduate professional

training, although it is still a relatively small proportion who go that far.

Employment of Women. This has a bearing on labor force figures, particularly the involvement of women in the labor force, and this is the last set of figures I would like to cite: between 1950 and 1960 the proportion of single women in the labor force actually declined slightly. The obvious explanation for this is that more of them are in school and college than were before, and therefore not in the labor force. The proportion of widows and divorcees in the labor force has been increasing slowly, but the proportion of married women living with their husbands increased from 24.3 per cent to 30 per cent in one decade -- an increase of more than 25 per cent in one decade, which is a truly remarkable jump. And this is not primarily because of economic pressure. Of course in terms of age, the increased employment starts in the middle thirties, and the peak of married women employment starts in the middle forties. In other words, when their children have reached a level where they do not require continual and detailed care, the mothers seek employment. Thus, not only is the typical adult man employed outside his household, but at important parts of the life's cycle his wife increasingly is gainfully employed outside the household, and more and more not primarily because of severe economic pressure on the family, but because of finding an alternative to child care and husband care when the child-bearing period has been so tightly compressed and longevity goes so much longer-- and longevity is associated with better average health than ever before.

Urbanization. This ties in, of course, with the obvious generalization

that the American family is becoming predominantly an urban middle class family. It is a very striking thing that, with the exception of a very few of the very rich, and unfortunately not so few of the very poor and handicapped, there is a remarkable standardization of family type and mode of living which is associated with the urban middle class and covers considerable ranges of standard of living level, but still with a certain very fundamental homogeneity. It is a relative fact that, family income equilization has not gone very far, but there has been some decrease in inequality over approximately fifty year period; and it is very clear that there has not been a progressive increase of inequality, which the Marxists have predicted for so-called capitalist society. The pattern has been, on the whole, rather stable.

This pattern of life now includes the single-family dwelling, and here there are two points that are especially interesting. The proportion of families living in single family dwellings has increased very greatly since the end of World War II, and the proportion of owner-occupancy also has increased greatly, of course greatly helped by Federal financing of home ownership and home building. But we have, then, the familiar pattern: the single family dwelling, the tendency to confine membership to members of the own nuclear family. This then is now the overwhelming norm. There is an absence of domestic service, except in the upper income groups for help in heavy cleaning; and in all groups, presumably, some kind of baby-sitting becomes an exceedingly important service. The familiar catalogue of durable consumers' goods — the automobile and the household items — constitute a highly capitalized household. It is quite expensive to equip a good urban middle class

household for the first time -- but there probably has never before existed such a broadly homogenized family pattern for such a large proportion of the population of the large scale society as this broad middle class urban pattern. Moreover, when I say middle class, I do not mean to imply a differentiation between white and blue collar. That is, the higher-income sector of the blue collar so-called working class population certainly should be included as living very much the same kind of life as their white collar cohorts, and of course very substantial proportion of the white collar group do.

THE NUCLEAR FAMILY AND THE EXTENDED FAMILY GROUP

Now let me say a little bit about the relation of this nuclear family to other relatives -- to what sociologists sometimes call the extended family group. I think perhaps I was the one more than any other single one who introduced into the literature of family sociology, the term "isolated", as qualifying the nuclear family, and I have been misinterpreted by certain people who maintain that this meant that all contact with persons other than members of this isolated nuclear family tended to be cut off. This was not the intention at all, but fortunately there has been research on extended family relations lately, and I think the situation is very considerably clarified. All of the things I have just been saying about the family and its household hold true, nevertheless; people do maintain relatively close relations to their closer relatives, but I would like to call attention to three points. First, there is a strong premium on basic independence. What I have said about household composition almost speaks for itself in this connection. It is not

considered normal to have parents of one or other of the spouses or siblings of one or other of the spouses living in the family household, and it has, in fact, been decreasing. The same applies to basic independence in financial support. It is not considered normal in the long run, and in the absence of emergency conditions for adults to be dependent on their relatives financially, outside the nuclear family.

At the same time there are two positive points. With respect to ordinary association there is a completely indefinite shading off between relatives and friends. It is quite correct, and in no sense invidious, to say that for a great many people their best friends are their close relatives, or that very prominent among their best friends are their close relatives. But this is selective and institutionally optional. If you have two adult and married siblings living with roughly equal geographical accessibility, you may have much closer relations with one than with the other, and it is not considered wrong to prefer one to the other. This would not be true to the same extent of living parents, and there would probably be trouble if the wife's parents were greatly favored over the husband's parents if both sets are living and both are geographically accessible. But as between siblings, the optional element, I think, is very prominent.

I think it very important indeed, that there is much accumulating evidence that the extended family is an exceedingly important resource to fall back on in case of emergency or trouble, for financial support and for emotional support and help in planning and all sorts of things of that kind. Wherever there is a real family crisis, particularly

involving one of the adult members, and therefore impairing the responsible leadership of the family, it is very common indeed for close adult relatives to be brought in in one form or another. Cases of serious illness or death are particularly prominent in this respect.

There is one particularly interesting case that touches a rather highly selective group, but nevertheless is worthy of note. In talking about dependence on relatives, the case is often cited of married students, especially with the great increase of graduate professional study and the lowering of the average age of marriage. A very large proportion of students in professional schools are already married. I think the primary help besides various kinds of official financial aids, whether scholarship help from the institution or from Government agencies or various other such sources, which have been multiplying rapidly, is the wife. Many more men than women go into graduate study, and some of you are aware, perhaps, of the reference to the fictional degree earned by the wives of graduate students -- the degree of PHT -- which means "put hubby through." As a teacher of graduate students, I am exceedingly familiar with this phenomenon, but I think that certainly parents, particularly, help out young couples in these respects a great deal. But even here there is a strong tendency to conceal what is really subsidy in the form of gifts -- in other words, so far as possible, to pay respect to the desire to be formally independent. And my own experience with this phenomenon would be that on the average, young couples feel very guilty about accepting parental help in these circumstances, and want to be freed of it as soon as they possibly can be.

FUNCTIONS OF THE FAMILY

Now let me turn to a few things about the broad functions of the family. With the extrusion of the family from economic production or vice versa, whichever way you want to put it, so that the farm family is no longer typical, and is only a small minority, and so on, there has been a lot of talk about the loss of functions of the family, and this is quite true. The family has become a much more specialized agency. It has, of course, the functions of taking care of the physical well-being of its members, providing a suitable place to sleep, to relax, where most meals are taken, for various types of recreation, etcetera, but most experts in the field would agree that the primary functions are a combination of psychological and social, very intimately intertwined with each other. In other words, dormitory accommodations would be much cheaper to manage if they were psychologically adequate, which, basically, they are not. I believe this is pretty well agreed to by psychiatrists now. The family system is a very expensive system, particularly in the expenditure of womanpower, but it seems to be very important, and it is important both to the psychological balance and security of its adult members, and of course as the primary agency of the psychological and social development of children -- what we sociologists call the socialization of the child. Psychoanalytic theory and sociological theory have converged on a new level of understanding of the importance of these functions and emphasis on how and why it is important and how and why it works. In particular, understanding is involved of the dynamic -- in the psychological sense of dynamic -- relations between the emotional needs of the adult, especially

in the erotic relationships in marriage, and, on the other hand, the children's experience in childhood in relation to their parents: the dynamic involvement, in other words, of the residua of childhood experience, which has become necessary in order to grow up to be an adult human personality, and of the needs that are gratified in the marriage relationship. But that is not all, because the relationship of marriage is so intimately tied in with the role of parenthood. Indeed, it is not going too far to say that, on the average, it is unlikely that a system of socially ordered erotic relations, heterosexual relations between adults, could function satisfactorily if it were not bound in with the normality of parenthood for those so related. There is a sense in which, as a parent, one recapitulates his relations to his own parents in reverse, and this is exceedingly important to his own psychological equilibrium.

We can, therefore, go so far as to say that on grounds of the theories of identification, internalization and that sort of thing in personality theory, the average adult human being has a strong, positive need to be a parent. This is not a sacrifice in the sense that he does it only from altruistic motives for the good of the race, without any deep grounding in his own personal need system. To be sure, we still find a few utilitarian-minded people who seem to claim the contrary.

THE FAMILY AND PERSONAL SECURITY

Let me now say something about a few sociological implications of this: The family is, above all, the ground of our personal security. It is the circle of people in whom we have the deepest implicit trust,

with whom we feel most at ease; we do not have to put up a front in the home. Family relations are quite sufficiently complicated, and yet I think -- and this holds broadly -- that ordinary normal people do feel more secure and more relaxed in the family circle than anywhere else. The very expression "feeling at home" with somebody suggests that it is with the people with whom we are normally at home, logically to say "with whom we do feel at home;" the point is relatively clear. I do believe there is much evidence that this grounding and base of psychological security which, with reference to child development, Erikson has called "basic trust," is of the greatest importance to the functioning of a society generally, and of our kind of society in particular. The fundamental problem concerns the basis on which people can be gotten to trust each other.

In this respect, the crucial relation in the family is the marriage relation. One very important aspect of the isolation of the nuclear family, if we use this phrase, is both the extent to which husband and wife, at least for a very long time, are thrown upon each other as the only adult members and who, therefore, are fully responsible members of the family unit, and the very strong emphasis on the voluntary character of the marriage relation, the whole pattern of marriage being one of purely personal choice with strong resentment of any intervention by any other agency. Meddling parents who want to try to marry off their children are most unpopular in the youth culture, a point of which I think we are all aware. This is all part of a very important complex. In other words, a man and a woman who can successfully make the kind of

commitment of loyalty to each other that a good marriage means, have accomplished an extraordinary feat of mutual trust. The very words of the marriage oath indicate this; this is no specific contract over specific interests like the contract of purchase and sale; this is for better, for worse, in sickness and in health, no matter what may come up. It is a very, very extensive commitment indeed.

Trust. It is this commitment on the part of the parents which is the basic ground of the security of their children. For example, the studies of the families of schizophrenic patients by Dr. Theodore Lidz and his associates at the Yale Medical School, has brought this out very sharply indeed. Then what about the rest of the society? I just want to point out that it is very highly dependent on mutual trust in relationships where the mutuality of obligations is fundamentally voluntary, and where obligation neither can be ensured by such inducements as monetary advantages, nor enforced by the use of authority. A contractual system, which has what the sociologist (Dunkheim) calls organic solidarity, is the typical system which is developing in our kind of society.

Let me give you only one example outside the family. This conference is particularly concerned with mental health problems, and of course this is part of the more general complex of treatment of health and health problems and illness by professional personnel. The average physician-patient relationship is established on hope. They are typically people who do not know each other in advance. There are some very long-continuing therapeutic relationships, but a very large volume of them are continually being newly established. While medical practice is a technical

matter of applied science, it is more than that. It is a relation between people, where a person in trouble and subject to disability, suffering, and so on -- and above all to anxiety about the future -- has to trust, in a very radical sense, somebody with whom he has had no previous contact or basis of trust.

Physicians often try to explain to **their** patients the technical basis of their recommendations, but I think anyone who looks carefully into these situations must realize that only in a minority of cases does the patient really understand very well the technical grounds of what he is asked to trust his physician to do. It is basically a matter of trust. In a technical sense, the physician is using influence beyond the range of possible basing of decisions on sheer information that the recipient can be left to evaluate for himself and in his own terms. The doctors like to say we must have confidence in our physicians, realizing that having confidence is doing more than carefully examining their recommendations on their merits. It is **confidence** in their competence on the one hand and in their integrity on the other. These are two essential components of willingness to trust. One of the grounds of this confidence is institutionalized, too, in the competence and integrity of members of an institutionalized profession. This is one reason why psychoanalysts have liked to identify themselves with the medical profession. They share in the general confidence in physicians and the problem of their acceptance is simplified to that extent.

One could cite many other examples. Let me only note, however, that there is a concurrent minority undercurrent of distrust in any

society which institutionalizes such relations of trust, and the medical one is a very prominent case. You will find in any community, and I am sure you find them among your clients, people who think doctors are all basically frauds. They are just out to get people's money illegitimately, and not to help them. There is this kind of an undercurrent. In fact, the undercurrent of distrust is perhaps the most prominent single social pathology of our society and underlies many, many more particular difficulties. We have encountered it in the political fields quite recently. I think, for example, that the major feature of the so-called radical right, and of their distrust of big government, is their generalized fear of entrusting their interests to anybody; in other words, the logical conclusion of the position is the position of maximum self-help, which is made a virtue of in inappropriate ways.

Very closely related to this seems to be the trend in the internal character of the family itself. I mentioned the voluntary character of the marriage relation. Typically, the family type which has been embedded in extended kinship systems and other kinds of functions than the ones I have emphasized as those emerging in the modern family, are more authoritarian and, to use a term of sociological jargon, are more ascribed -- that is, people are expected to do what they are expected to do by virtue of their status, and parents are supposed to be in a position simply to assert their authority. "Why should I do this, Father?" "Because I say so, and I am your father." No further explanation is required. We know that parents are not getting away with that anymore, at least beyond the quite early ages of their children.

It seems to be in the cards of the whole trend of the development of the society that the family, which is so basic to the system of solidarity and trust, should itself be a group of people who maximize their mutual trust in each other. I stress this for the married couple, but I think the bringing of children into this system of mutual trust as early as possible is an inevitable trend; namely, treating them as autonomously responsible people. I do not think we have yet worked out the balances. Very large proportions of our families are still in transition from very different types, and other social changes have been going on. Quite clearly there are limits. You cannot trust an infant as a completely responsible autonomous person. Indeed, undoubtedly we trust many of our children too far. We overload them too much. And the same kinds of difficulties arise with children that arise in marriages: the high divorce rate, for example, is probably much more due to the heavy burden placed on modern marriages than it is to a decay of marriage in any sense resembling a development of a basic indifference to marriage. The combined facts of the increase in the proportions married and living with their spouses and the voluntary acceptance of the responsibilities of parenthood pretty well dispose of the indifference theory of divorce. It is because people are saddled with a very difficult job (making a good marriage is not an easy thing) that so many of them fail. It is not the other way around, that they fail because they have not even tried.

THE EXCEPTIONS TO HOMOGENEITY

Finally, let me say a word about the big and serious exception to

the picture of a relative homogeneity, and a relative definiteness of patterns of the family. We can say that we have a new lower class in Western industrial societies, generally, and in more accentuated forms in our own society. If you take some of the interesting family studies that have been made of lower class groups in England, the Bethnal-Green studies, for example -- a working class suburb of London -- it is clear that there is a kind of an institutionalized lower class status that is much less prominent in the American picture, in the urban slum populations; our slum populations are much more disorganized. They are much more, in a certain sense, the rejects of the main society. This certainly is not true of traditional peasant populations, and it is not true to the same extent of the older European working class. They are people who, in one sense or another, varying greatly, have failed individually. But I think we could say very much more: they are today the record of failure of the society. The situation is made doubly difficult and complicated by the fact that very important sectors have never really been admitted to full membership in the society. I think here particularly of the Negro -- traditionally a segregated rural group, but who, with migration into our cities and with urbanization, has become not only realistically a very important part of this lower class group, but almost the symbol of it.

We all know that a variety of social problems tend to concentrate in these groups, not in the solidly-based working class I spoke of before. For example, some of you may know about the study of gang delinquency being carried on in the Boston area by Dr. Walter Miller. He has published a few articles and has a book in press. If he divides

what he calls working class boys by fathers' occupations and education into three categories, he finds that gang delinquency is almost non-existent in the top category working class. It is relatively infrequent and mild in the middle category, and it is overwhelmingly concentrated in the lowest of the three categories. Moreover, if he standardizes for socio-economic status on this basis, he finds that race makes no difference. There are larger numbers of delinquent acts by Negroes, but only because there is a larger proportion of Negroes in this socio-economic status, not because those who are there are individually more delinquent.

I think this is a general pattern, pretty much across the board. And I think it is a very interesting thing that the nation is beginning to awaken to the seriousness of this. That is, the American version of the welfare state, which roots in the middle class, has not really solved this problem. I am sure we will all agree, but it has left an enormous residual element still to be coped with. The famous Swedish economist, Guerner Meerga, has recently written a book very strongly emphasizing this, essentially on this question: Is America as affluent as it purports to be? And President Johnson has already announced an intention to take the problems of poverty and related problems very seriously as a Federal responsibility.

In closing I would like to say only one thing about this: I certainly think that economic help is crucially important. But I am inclined to think that it is likely to be ineffective if it is not accompanied with the reciprocal of the mutual trust that I have been

emphasizing with reference to the family, and been suggesting is very important, permeating our whole society. The fundamental problem of the Negro is not that he is poor, but that he is excluded from full acceptance in the society. If he were fully accepted, nothing like as large a proportion of his race would be poor. I think, therefore, it is exceedingly important to discriminate the non-acceptance based on color from the lower class status, and one of the barriers to a better civil rights position has been the tendency to tie these together and to say "Look at him; look at the proportion of the drop-outs from school who are Negroes; look at the low IQs; look at the low occupational status; and so on". Obviously it is a vicious circle. I do think that the social side, as distinct from the economic, is likely to be as critical as the economic; indeed, I would go even further and say, it is likely to be even more critical.

her job. The work, so she said, required more dedication than she was able to muster. The situations which she encountered were too frustrating to her. The needs of the clients seemed overwhelming, and there was no little she felt she could do.

I believe there is a connection between her sense of frustration and her lack of dedication. Had the young woman experienced less frustration, she would have developed the dedication necessary for this kind of work. Most likely she applied for the job because some factors in her personality caused her to be interested in people and interested in ways to relieve human suffering. She undoubtedly had a potential for dedication, and she tried to do something that corresponded to her image of herself. She might still be working with the EPA had she been able to recognize

THE UNIQUE OPPORTUNITIES OF PUBLIC ASSISTANCE

WORKERS TO HELP FAMILIES IN CRISIS

Alexander Rogawski, M.D.

The young daughter of a friend of mine, shortly after her graduation from college, decided to work as a social caseworker for the Los Angeles County Bureau of Public Assistance. She must have been attracted by the Bureau's recruitment folder, which says that few positions offer "the variety of experience, the challenge and the satisfactions" which the job of the social caseworker offers.

Some time later I learned from my friend that his daughter had quit her job. The work, so she said, required more dedication than she was able to muster. The situations which she encountered were too frustrating to her. The needs of the clients seemed overwhelming, and there was so little she felt she could do.

I believe there is a connection between her sense of frustration and her lack of dedication. Had the young woman experienced less frustration, she would have developed the dedication necessary for this kind of work. Most likely she applied for the job because some factors in her personality caused her to be interested in people and interested in ways to reduce human suffering. She undoubtedly had a potential for dedication, and she tried to do something that corresponded to her image of herself. She might still be working with the BPA had she been able to recognize

her job as meaningful, as ultimately useful, and as one which no other profession in our current social structure can perform with equal effectiveness.

Work, even if not sweetened by the sense of immediate achievement and by demonstrable results, is less frustrating when it is experienced as part of an essential and major purpose.

In this address I shall endeavor to share with you my impression that this holds true for your work as social caseworkers in the field of public assistance.

For more than three and a half years I have been associated with your agency as your Mental Health Consultant. I am not an employee of the Bureau of Public Assistance. I am a contractual employee of the Los Angeles County Department of Mental Health* delegated to the Bureau to explore and promote ways by which my profession can contribute towards greater satisfaction of people involved in public assistance functions, clients as well as staff.

In more than 130 conferences I have met a good number of your colleagues: caseworkers, supervisors and administrative staff. As a psychiatrist, and thus as a member of a different profession, I had a great deal to learn about the nature of your work, about the principles involved in the government's participation in programs of social welfare, and about the circumstances under which you perform your many complex functions.

*This agency provides psychiatric consultants to public and private health and welfare agencies in Los Angeles County.

Some of you may remember that I accompanied you on your home visits or sat in while you interviewed clients. I had an opportunity to learn of some of your problems through the questions you addressed to me at our mental health consultations. I have been impressed by the hugeness and the complexity of the tasks which you face daily in the exercise of your profession. I can understand how the young woman felt who quit her job as a social caseworker because she found herself overwhelmed by the needs of her clients. Yet I have also been able to recognize that, difficult though your job is, some of its frustrations can be avoided and some can be compensated by great satisfactions.

A careful consideration of your role vis-a-vis your clients and of the circumstances under which you meet many of them will make you aware of unique opportunities which, if used correctly, have a much greater effect than you may have realized on the individuals and families with whom you are dealing, and on the state of mental health in our community at large.

THE ROLE OF THE PUBLIC ASSISTANCE WORKER

Your primary responsibility is to provide "financial assistance in appropriate amounts to families and individuals who meet eligibility requirements." Yet far beyond these primary responsibilities you are playing a most important role in the lives of your clients. You cannot help it. The position of influence is yours by virtue of your role and as consequence of the critical circumstances under which you usually enter your client's world. A considerable portion of our population will be

deprived of potentially available professional assistance unless the potentialities of your functions are exploited. The number of your clients alone represents a sizable percentage of our community. An even larger group of people who entertain significant relations with your clients are also affected by their state of mental health.

Within the system of professions concerned with the health of individuals as well as with the health of the community as a whole, you hold a place which nobody else can fill equally well. You have access to a segment of our population from which, for reasons not fully understood, issue an inordinate percentage of our most severe mental illnesses.

Lest you get the impression that I have come to burden you with what is clearly and primarily the responsibility of the psychiatric profession, let me quickly allay your apprehensions. I am not trying to make psychiatrists or clinical psychologists of you. Your functions and the functions of other professions complement each other. We are working in different though related areas of competence. What is needed urgently today is better collaboration among the various professions and clearer definitions of the several roles.

In my contacts with you I have observed that you feel at a disadvantage because you lack the educational background of psychiatrists, psychologists, and psychiatric social workers. You are aware how much and how often emotional disturbances complicate the situation of your clients and interfere with their emancipation from public support. Their economic plight is often caused by emotional difficulties, and these economic and emotional factors aggravate each other in a vicious cycle.

It is here that many of your frustrations in your work originate. You begin to feel that had you only the knowledge and the know-how of a psychiatrist or a member of the related professions you would be able to help your clients more effectively.

Sometimes this is true, but probably much less often than you think. The psychiatrist is specialized in specific approaches and techniques best fitted for specific conditions. Though your client may be an emotionally disturbed person, in need of some help, he may not be suited for psychiatric therapy. In such instances the approaches and professional techniques of the public assistance worker may be more effective and more beneficial than that of the psychiatrist.

Later I shall discuss this point in greater detail.

When I stress the importance of the role of the public assistance worker at the level of the currently required educational qualifications, I do not wish to be misunderstood as speaking against advanced graduate education. The more you know, the greater your understanding, the deeper your satisfactions in your work and the greater the benefits for your clients. For good reasons, many social caseworkers decide at some point of their career to return to school for additional education.

But it should be recognized that additional education may in fact remove you from certain essential posts. I am reminded here of my experience in the Army. Some of the doctors did not wish to be promoted beyond the rank of major. They knew that as soon as they became lieutenant colonels or higher, they would become administrators, chiefs of Departments or hospitals. In this new post they would lose the

gratifications of direct patient contact and the pleasures of actually practicing medicine.

In a similar way, the more education you have the more ambitious your goals, the more expensive your time, and the more selective your choice of the people on whom you wish to concentrate your efforts. Today I hope to show you that a large segment of your client population can derive considerable benefits from people with your level of professional training.

THE CONCEPT OF CRISIS

In order to demonstrate my thesis that you, as public assistance workers, have unique opportunities to help families in crisis, I shall have to acquaint you with a way of looking on human functioning in terms of emotional health and illness. The basic concepts which I shall present to you have been worked out by Dr. Gerald Caplan, Associate Professor of Mental Health, Harvard School of Public Health at Harvard University. Dr. Caplan has employed these ideas successfully when dealing with problems in the field of preventive psychiatry.

The level of mental health of any individual can be rated on a scale. One pole of this scale would represent the state of optimal mental health. The opposite pole would correspond to the disabling conditions of severe mental disturbances. I shall not go into the difficulties of defining scientifically what optimal mental health means. We do not have any scientific ways to determine accurately the degree of mental health or illness in a person. But we all know that some people

can take life's adversities better than others. Let us therefore agree that the more able a person will show himself as continuing to function in the face of the various inevitable stresses of daily life, the higher we shall place him on our scale and the closer to the pole of optimal mental health. Conversely, a person who becomes easily disorganized and unable to function even under routine living conditions would be rated low on our scale.

Whatever a person's rating may be, high or low, this is his baseline, his customary level of performance. As he is assailed by daily frustrations, by minor threats to his security and to the gratifications of his needs, he will become temporarily upset. As a rule he will quickly regain his usual equilibrium.

Inevitably during a lifetime all of us get into situations which threaten even this basic equilibrium. We become confronted with problems which we feel unable to solve by ourselves, we experience losses which seem to us unbearable, our status or our relationship to other people changes abruptly, overwhelming responsibilities are thrust upon us. Whatever the cause, we become upset and anxious and we function below our usual level. We call such a period of severe emotional upset a crisis.

A crisis is a temporary condition. Whatever causes the disturbance either passes sooner or later or, if the change is permanent, the individual adjusts to the new conditions and settles down to the daily business of living.

Your profession deals constantly with people in crisis. This is

often the time a person will turn to the agency for assistance. After your clients have been helped over the initial distress, they become easily overwhelmed by new difficulties, since their resources are often quite meager and they live under precarious circumstances. What we have learned about crisis states should, therefore, be of interest to you:

First, it was found that people emerging from an acute crisis may return to the level at which they were functioning before the stress. Yet, they also may settle at either a higher or a lower level of our hypothetical mental health scale, and then they continue to function around this new equilibrium.

It is easy to understand why a person would be left shaken in his self-reliance, more or less permanently, after he has gone through an experience of feeling overwhelmed and unable to take care of his basic needs and responsibilities. We expect him to be apprehensive lest he meet with another debacle. But some people, contrary to such expectations, come out of a crisis stronger than they were before. The crisis affects them like a learning experience. Such people discover strength and resources within themselves they did not know they had.

Second, the outcome of a crisis is markedly dependent on the availability of people with whom the person in difficulty can entertain meaningful and supportive relations. Such persons may be members of the family, or they may be friends. They may, like public assistance workers, be professional or non-professional representatives of community groups or agencies whose function it is to help people.

Third, people in a state of crisis are more easily influenced by

others than at any other time of their lives. Insensitive treatment by people important to them may aggravate their distress and drive them into impulsive, irrational and self-damaging behavior. Conversely, they will respond readily to appropriate interventions by the right person. In their unstable state they look for direction, even if this is not always clearly evident. Their customary defenses are shaken even while they may try to save face in apparently uncooperative attitudes. In the state of crisis they may listen and accept assistance which they rejected previously. Most important: an appropriate intervention will not merely alleviate the acute emergency. It may affect the person so effectively as to move him out of the crisis towards a position of permanently greater strength.

In other words, the moment of crisis is a valuable opportunity to achieve optimal results with relatively limited interventions.

VARIETIES OF EMOTIONAL PREDICAMENT AND RANGE OF APPROACHES TO HELPFUL INTERVENTION

Society has developed a wide range of specialists whose function is to help people in difficulties in a variety of specific approaches.

Whenever people have problems, emotional factors are involved in some way and to a varying degree, either as casual determinants or as concomitant aspects, or both. At times it may be difficult to decide which specialist is best suited to help a person in a specific predicament. Someone may be planning a divorce and go to a lawyer, and find himself referred to a psychiatrist because the lawyer questions the soundness of the person's judgment and the validity of his decision.

Whether a person consults a psychologist or turns to a clergyman for help will be determined more by his background and his beliefs than by the nature of his problems. In many medical conditions the treatment of the emotional factors is at least equal in importance to the therapy of the physical aspects of the illness. This means that all help-offering professions deal with emotional factors, and the decision has to be made as to whether they can do this within their own specific professional competence, with the repertory of their own specific professional technique, or whether they should either collaborate with or refer their clients to the specialists who work with psychological problems.

Where do you, as public assistance workers, fit into this system of help-offering professions? Though your clients come to the agency applying for financial assistance, their economic distress is often only one, and frequently not the most obvious, expression of an emotional disturbance. Several times each day you are forced to recognize that the check which you have secured for your client alleviates only part of his misery. The basic problem remains unaffected. Financial support alone will not restore his self-respect or motivate him towards self-support. In fact, at times it seems like a beckoning towards chronic dependency.

In your training program you were taught the skills of social casework, procedures akin to some forms of psychotherapy, and throughout your supervisory contacts you are encouraged to use them. But how far should you go? And how far can you go on the basis of your limited training?

What chances do you have to do any good? Your work is so demanding

- - with the huge case loads, the perpetual paperwork, the phone calls, the interruptions, the various petty harrassments - - that there is little time left for the individual client and his family. With all these limitations, can you really do anything of value beyond making sure that the client gets that to which he is lawfully entitled?

How much responsibility can you bear? When should you call a psychiatrist for help? When should you prevail upon the client to apply for therapy at a clinic? When should you urge him to admit himself voluntarily to a hospital? When should you urge the relatives to accept responsibility for commitment? What can you do when an obviously disturbed client refuses to permit a psychiatric evaluation? Indications for psychiatric treatment seem so ill-defined. It is difficult to get a psychiatrist to step in and take over except in the instances of the most severely disturbed patients. Whether someone becomes accepted for psychiatric treatment seems sometime to depend less upon the degree of his need than on the availability of treatment facilities, on the patient's prognosis, on his background, his educational level, and last but not least, whether he can pay for therapy.

The distinction between what is called "emotional disturbance" and "mental illness" is vague. Unless a patient suffers from a condition with clear-cut major symptoms, even physicians may disagree on the classification of his disturbance. It is not surprising that this state of affairs has left you bewildered.

Time and again in our mental health consultations you have asked me all these questions I have just enumerated. I cannot give you specific

answers in the brief time at my disposal. With some of you I have already discussed similar topics in our conferences. I assume that many of these questions will be dealt with in some detail in the workshops which are to follow the Institute. We are also in the process of developing a program where gradually more and more of you will have the opportunity to consult psychiatric consultants on specific problems.

Today I wish to define for you where I believe you stand and ought to function in the overall scheme of our efforts to alleviate the many difficulties and problems in various segments of our population. If you are clear about your role and position, I believe you have a basis for the answers to your questions.

Several years ago Dr. Frederick C. Redlich, a psychiatrist, and Dr. August B. Hollingshead, a sociologist, both members of the faculty of Yale University, conducted a study of current forms of psychiatric practice. The results were published in a book entitled: Social Class and Mental Illness. Dr. Redlich and Dr. Hollingshead found that the diagnosis and the type of therapy which a psychiatric patient was likely to receive was related to his economic, educational and social position within our social structure. At first this seemed contrary to our American ideal of equal opportunity for all. On closer examination it turned out to be less unfair than it was thought initially.

The variety in treatment approaches is not just the consequence of the high cost of individual private psychiatric care which limits its use to a privileged group. Some forms of psychotherapy, especially psychoanalysis, rely for their therapeutic effect on verbal transactions and

influence by ideas. In order to be successful, such therapies presuppose a certain degree of sophistication and the patient's expectation that talking and being listened to can actually be helpful. Attitudes like this are more frequently found among professional people and members of the affluent layers of society.

In an over-simplified generalization we may describe current conditions with regard to treatment of emotional disturbances and psychiatric disorders as follows:

People belonging to the upper strata of our population, or people with a certain degree of sophistication, will turn to psychiatrists not only when they suffer from clear-cut mental illnesses. They will consult the psychiatrist for a wide range of problems which they understand or which at least they believe to be due to emotional maladjustment.

They seek help for career frustrations when they feel that something within them prevents the full development or utilization of their abilities; for interpersonal difficulties with their spouse, with their children, with colleagues, with friends; for so-called psychosomatic illnesses; for vague discomforts and dissatisfactions with life in general; and for a multitude of other complaints.

Treatment consists, most frequently, of more or less intensive psychotherapy. Conversely, the rest of the population becomes involved with psychiatry only or most often in cases of emergency: when people have become incapacitated by a severe mental disease; when they are suicidal or dangerous to others; when they have broken a law and authorities or attorneys

suspect an underlying mental illness.

Treatment in these cases consists most frequently of hospitalization, organic therapies such as electroshock or drug treatments, with psychotherapy usually playing a secondary role.

And what about the people between these two alternatives - - people who have emotional problems, who could benefit from help but who neither fit the qualifications for formal psychotherapy nor are sick enough to require hospitalization or organic therapy?

THE TROUBLED "UNPATIENT"

For want of a better expression, let me refer to these people with regard to psychiatric treatment as the "troubled unpatient group." They are not representing a specific diagnostic category. They may be less disturbed or more. They are troubled people, but for a variety of reasons within themselves or in their environment they are not suitable for any of the currently used standard treatment techniques of psychiatrists or those professions such as clinical psychologists and psychiatric social workers who use similar therapeutic approaches.

I submit that a large percentage of your clients, insofar as they have emotional problems, belong to the "troubled unpatient group." (I believe it can be said that all your clients to a varying degree have emotional problems, in the most comprehensive sense of the word.)

You know how difficult it is to arrange for psychiatric treatment for any of your clients. Facilities providing minimum-fee or free

psychiatric treatment are filled to capacity, and often they have long waiting lists of applicants. But even if it were possible to get every one of your clients to see a psychiatrist, I maintain that for many this would be a useless, and for some it would be a harmful, measure.

Here are some of the reasons:

First, limitations of verbal facility and lack of sophistication make some of your clients poor subjects for the climate of the psychotherapeutic situation, with its heavy reliance on words and ideas in a relatively controlled emotional atmosphere. These people respond more effectively to acts, gestures, actions and emotional exchange.

Second, many of your clients lack motivation for psychotherapy. Moreover, often they have shown in the past that they lack consistency in the pursuit of vital interests. They have little tolerance for frustration, and psychiatric therapy frequently requires that the patient be able to stand frustration. In many instances your clients would neither be able nor willing to keep regular appointments with a psychiatrist for the period of time necessary for good results.

Third, among the goals of psychotherapy is the restoration of existing skills and abilities by freeing the clients from the interfering influence of distorting emotions. In many of your clients there are no skills or abilities to restore. They were never acquired, due either to a lack of endowment or to an absence of learning opportunities. If a person spends money foolishly because he is upset, psychotherapy may help him by reducing the underlying emotional agitation. If a person has never learned how to budget his funds, it is not psychotherapy he needs, but a

person who shows him how to do it. in your office, and especially when in

Fourth, for many of your clients, anything that has to do with psychiatry has a frightening or demeaning connotation. They suffer from the prejudice that going to a psychiatrist means as much as admitting that one is a "nut" or "crazy." Thus a referral to a psychiatrist is considered an insult and likely to reduce further an already low self-esteem.

I further submit to you that public assistance workers are singularly suited to help the client belonging to the "troubled unpatient group." Here are some of the reasons:

One is that in contrast to the psychotherapeutic situation, your relationship to the client is, in addition to whatever is transmitted by words, full of other conscious and unconscious emotional transactions. The very fact that you are giving very realistic assistance in the form of financial support and various other services has a bolstering impact on your client which transcends the material aid rendered. Do not underestimate the meaning of the monthly check. It is more than money. It is also evidence for many recipients that they are part of a social group.

You visit your clients in their homes, you chat, you ask questions, you counsel them, you learn to know the family in person, the house, the environment - - parameters of contact outside the standard psychotherapeutic techniques. The client's ability to verbalize, and his degree of sophistication, are of less importance in a relationship of this kind. But it is important to realize that he responds to your acts, gestures, actions and to you as a person, to a much greater extent than if you

were sitting in relative anonymity in your office, and especially when he does not see you while he is lying on the couch.

It is therefore essential to observe yourself, your behavior, and your reactions in your contacts with your clients. These self-observations will sharpen your sensitivity, will teach you what the client is doing to you and, perhaps, similarly, to other people. They also will sharpen your skill in using yourself, your assets and your limitations as tools in your efforts to help your clients.

A second reason is that while the patient of the psychotherapist must bring with him a strong wish for treatment, your client's motivations are reinforced by his interest in keeping the check coming, at least for as long as he needs it. You are required to seek him out and visit him at his home from time to time. This reduces the client's responsibility for the maintenance of the relationship. A psychiatrist cannot ethically pursue a patient who first misses and finally stays away from his appointments.

In every help-giving relationship the recipient is liable to develop resentments against the help-offering person. It is in the nature of your professional role to reduce such resentments as much as possible by turning them against outside areas. You try to establish as positive a rapport as possible, so that you get into the position where you can make graduated demands on your client, moving him towards positions of greater self-care and strength. For technical reasons the psychotherapist must often not avoid the negative feelings of his patients. The expression and recognition of resentments becomes a therapeutic tool. The

psychotherapist must often confront his patient with insights which the patient will resist and to which he reacts with hostility. Only his initial strong motivation will keep him in treatment in spite of such discomfort.

You do not have to do this, because this technique is outside of your professional area. In keeping with the much lower motivation of your unpatient, you are trying to affect him by establishing and using positive rapport.

A third reason is that it is part of your professional activities to compensate for the absent skills and abilities of your clients. It is obvious that you must often play the role of a supplementary "ego" if the client's ego is deficient. If the client has not acquired certain skills because he never had anyone to teach him, you become in fact something of a teacher, and at the same time a model to follow. You show him how to make a budget, how to get along on a specified amount of money, you steer him towards acquisition of new skills and rehabilitation.

If you are able to establish proper rapport with him he will wish to identify with you, he will wish to please you, and he will put you into the role of a parent he never had but wished he would have had. Permit me to remind you that one and the same activity can be seen from at least two vantage points: as a realistic activity with a stated and obvious purpose, and as a carrier of emotional transactions with a personal meaning for your client -- a meaning which may be inferred by you from the totality of his behavior.

There is a fourth reason. As a public assistance worker you are not safe from unpleasant associations in the minds of many of your patients. Your presence is an embarrassing reminder of their need for public aid, evidence of having failed or of being injured. Some clients will hide their negative attitude, defending themselves by various rationalizations against the embarrassing admission that they have to be on relief. But even though negative feelings are always there, they are not as strong as the reactions many people have against the psychiatrist.

In the foregoing, I tried to describe the advantages you have over the psychiatrist when it comes to dealing effectively with the "troubled unpatient person," the type you are most likely to encounter among your clients.

I tried to show you that the techniques of your profession are better suited for dealing with this kind of person because:

- you can rely more on action help than on words, and this kind of person is more sensitive to action;

- your approach makes less demand on his often reduced tolerance to frustration;

- your approach takes into consideration ego deficiencies which are not affected beneficially by psychotherapy, and your clients are likely to have this kind of ego deficiencies; and, finally,

- you are not affected by the often vehement prejudices against the psychiatric profession.

I am sure you have many questions to ask, especially how this conceptualization of your role can be translated into your daily work. I

assume you will raise some doubts and objections and I wish to anticipate at least two: it is obvious that the classification "troubled unpatient group" is not a designation that a person must retain for life. He may in fact rise to the level "untroubled", which, if it does not indicate a pathologic denial of his troubles, would mean achieving a state of relative harmony with himself and his world.

But our "unpatient" also may change into a voluntary or involuntary patient. You are, of course, concerned when a client of yours should be urged or forced into psychiatric care.

Here the history of the client is of great help, and sometimes also the often voluminous records in your files. It is remarkable with what degree of emotional disturbance a person may continue to function reasonably well in restricted sectors of his life. And as long as he can safely remain in the community, even though he may be at times a nuisance to himself and to others, he is better off there than in the hospital. The warning signals are signs of progressive and malignant personality disorganization, such as marked deviations from usual behavior.

INTERVENTION BY THE PUBLIC ASSISTANCE WORKER

In this area the public assistance workers perform an extremely important function: With your access to a large number of considerably disturbed persons who are not ill enough to be hospitalized and yet not well enough to remain unobserved, you act as a monitoring agency. You are keeping your fingers at a sensitive point of our total community mental health structure, watching for those changes of progressive deterioration which may force us to bring a person to the hospital, even against his

will. Moreover, the time you spend with your clients is often very limited, once a month or less often, for a brief period. How could anyone claim that you exert such important influence on your clients? To this question permit me to reply in this fashion:

One point that bears emphasis is that your role differs from that of a psychiatrist not only in the approach to the client's problems, but also in the goal that is to be achieved. The psychiatrist and his patient engage in their endeavor, so expensive in effort, time and money, because they hope to achieve a change in the internal structure of the patient's person. It is not your obligation to "treat" patients in this sense. You want to help your client to function as well as he did before he became a recipient of public aid. Your goals can be limited and realistic, and in fact they must be so if you wish to spare yourself useless frustration.

I want to note, too, that the concept of crisis was discussed in order to show you that at times a person can respond favorably to relatively minor interventions. You must not underestimate your importance for your clients. Even if you are not with them in person, you are in their lives. Just the fact that there is someone they can call when they are desperate may reduce the feeling of being abandoned in their helplessness. If no one else can give them help, your existence may affect the outcome of their crisis in a beneficial direction. Consider the fact that in the world of some of your clients you are the best adjusted person with whom they come in contact.

Furthermore, the model of psychotherapy with its intensive and prolonged patient-therapist contact has contributed to the myth that this is

the only, or at least the best way to help people with emotional difficulties. While this is true for specific individuals, everybody knows from his personal experience that a certain remark, a gesture, an incident, an act at the right moment, may have influenced him more strongly and more beneficially than hours and hours of meaningless presence. We must free ourselves from the erroneous assumption that only intensive and time consuming therapy can be truly of help. With regard to the goals to which you aspire in your clients, and under the circumstances of your work, a relatively brief but meaningful encounter has better chances to succeed.

There are many more thoughts which I would like to share with you on this topic, but the time allotted to me is drawing to a close and we shall probably have an opportunity to take up some omitted items in our discussion. Yet there are three brief remarks which I would like to make before I close:

First of all, my talk today was intended to acquaint you with a conceptual framework. I wanted to show you that you have a place which no one else can fill. Yours is not a second class citizenship but a specific professional role in a specific sector, side by side with other help-offering professions.

Second, the purpose of my talk was not to give you specific recipes for behavior and action. This cannot be done meaningfully with an audience of this size. The implementation of these ideas will be the responsibility of your workshops.

Third, I wish to use this opportunity to thank you for having invited me to learn from you, to work with you, and to combine my skills

with yours to tackle this formidable job of yours, which could be whimsically described as a "Do-It-Yourself Peace Corps at Home."

THE SOCIAL WORK OF A FAMILY
RESEARCHER'S GUIDE

FRANCIS S. BROWN

Since the phrase "hard core family" was coined some years ago, a number of descriptive categories have clustered around it. All of us, I believe, working in the field of social work have seen this term in use, including the following: a family having no work problems, all of a chronic nature, that are expressed possibly in financial dependence, physical impairments, personality problems, anti-social behavior, a family that consumes and drains community resources, that is a loss time source of cost and contribution to the community, a family that frustrates and angers all who deal with its members because they stubbornly pursue their own ends and refuse to accept or use help that might make conditions better for them and the community.

These families, well known in every department of public welfare, are the subject matter for endless study by supervisors and administrative conferences that usually are followed by a burst of activity by the worker with the family, followed in turn by understandable discouragement and apathy in what appears to be a never ending cycle.

They are the subjects for concern and attack by legislative bodies and, indeed, are a sore in the body politic. But are they really as hopeless and helpless? Must all resources be poured into them as into a bottomless well, or can any of these families be enabled to do things

MEETING OF THE SOCIAL NEEDS OF A FAMILY
RECEIVING PUBLIC ASSISTANCE

Frances H. Scherz

Since the phrase "hard core family" was coined some years ago, a number of descriptive connotations have clustered around it. All of us, I believe, conjure up the same constellation of ideas when this term is used, including the following: a family beset by many problems, all of a chronic nature, that are expressed socially in financial dependence, physical impairments, personality problems, anti-social behavior; a family that overuses and abuses community resources, that is a long time source of cost and irritation to the community; a family that frustrates and angers all who deal with its members because they stubbornly pursue their own ends and refuse to accept or use help that might make conditions better for them and the community.

These families, well known to every department of public welfare, are the subject matter for endless costly hours of supervisory and administrative conferences that usually are followed by a burst of activity by the worker with the family, followed in turn by understandable discouragement and apathy in what appears to be a never ending cycle.

They are the subjects for concern and attack by legislative bodies and, indeed, are a sore in the body politic. But are they really so hopeless and helpless? Must all resources be poured into them as into a bottomless well, or can many of these families be mobilized to do things

in their own behalf? Can the sore be healed, or at least healthy scar tissue be formed that enables the family to become a contributing, not depleting, part of the community? I believe the public agency worker already has or can develop the knowledge and skills to work effectively with these families.

A "HARD CORE FAMILY"

Basic Operational Goals. Today I shall describe a so-called hard core family, the J. family. This family is typical, but the kind of work undertaken with them and the fine results unfortunately are not as typical as one wishes to see. I would like you to keep in mind the various purposes for which intensive and extensive work was undertaken with this family: 1) to preserve the family unit; 2) to help Mr. J. develop his full potential as a parent and head of the household; 3) to help Mr. J. establish confidence in himself as a worthwhile person with much to give to his family, his job, and his community; 4) to help him find an escape from chronic dependency - emotional and financial; 5) to demonstrate what can be accomplished with consistent, concentrated use of casework and other services and resources for the purpose of preserving family life; and 6) to demonstrate that the use of these services is a sound investment in dollars and cents as well as in human values.

These purposes and goals can be replicated many times with many families. They are basic operational goals for all social welfare programs. It is in the achievement of those goals with regard to the J. family that I hope to show how the public welfare worker can operate effectively, what it requires by way of knowledge and skill, and what resources need

to exist and to be utilized.

The First Ten Years. The J. family, as of April 1960, the date when they were transferred to Child Welfare Services case load from a General Assistance Division case load*, consisted of Mr. and Mrs. J., aged 34 and 33 respectively, and five children ranging from eleven and a half years to eleven months. The transfer was made for two main reasons. One, it was thought that placement of the children might be indicated because there were persistent complaints from neighbors, schools and stores that the children were neglected physically, were wild and destructive to property, that they begged interminably for food from store-keepers and neighbors, and that they were unmanageable in the school. Two, it was hoped that in a special unit where case loads by plan were kept small, it might be possible to find some way of working with the family without placement of the children. It had not been possible to provide close attention to the J's in the General Assistance Division because of large case loads which meant that most families had only sporadic contacts with a series of workers.

The family first came to the attention of the Department of Welfare during 1950, when Mr. J. applied for assistance toward meeting a hospital bill incurred because of an appendectomy. For the next ten years, the family received public assistance off and on - - mostly on. Mr. J., an unskilled laborer, seemed unable to hold jobs because of a chronic chip-on-the shoulder attitude. There were also periods when he could not find jobs because of his lack of skill and the general dearth of employment

*The Child Welfare Services case loads in the agency serving the J. family are comparable to those designated as "neglect files" in Los Angeles County.

possibilities. During these years there were constant references in the record to the agency's inability, despite efforts, to alter the situation for the better. Different workers tried persuasion, threats and suspension of financial assistance. Nothing seemed to work. When pressed to the wall Mr. J. would work for a short period; when encouraged, the same thing would happen. Mr. J. was suspicious, unfriendly, complained of physical ailments such as kidney and back conditions and a need for dental care. But he refused medical attention, fearing it would create the impression of his being "weak". Mrs. J. seemed unusually shy, dull, unable to manage the children, unable to run the household or to do the simplest of tasks. The children were dirty, ill fed, out of control, and at the time the family was transferred to Child Welfare Services, the eleven-months old baby appeared to be quite forgotten. He lay in a bassinet in a corner of the dark living room and very rarely was moved from that spot. He was small, thin, listless, and, despite a bulging belly, appeared undernourished. Mr. J. was the cook for the family; although he worked rapidly and efficiently, meals were usually simple, unappetizing and not nourishing, consisting largely of starchy foods. The ramshackle house had little furniture, and this was shabby and broken. The family picture was one of serious disorganization.

Toward a Working Relationship. Let us see what happened between 1960 and June of 1962 -- a period of two and a half years. The first matter at hand was the effort to establish some kind of working relationship with the family. It was recognized that unless this was attempted, it would not be possible to learn why the family was in such bad shape, what possible areas of health existed and what alleviating measures could

be undertaken. Facts - - reality facts and psychological facts - - were needed, but how to get them was the problem.

The worker visited regularly, weekly. He began with Mr. J's expressed concern: the fear that the children would be taken away because of the many complaints. Mr. J. said he would kill anyone who tried to do this because they were all he had to live for. His threat seemed to be real. While no assurance could be given that the children would not be removed, Mr. J. was assured that this was not the intention at present and that the agency's wish was to help the family to begin to manage themselves better. Mr. J. gradually began to talk about his problem, his feeling that nobody liked him, that everybody was against him, that he could not work because he had to stay home and take care of the children because his wife was incapable of doing anything. The worker knew Mr. J. had been in jail several times for assaulting his wife. Mr. J. explained that he could not control his temper when he saw how inadequate and lazy she was in caring for the children and the home.

Over a period covering a number of months Mr. J. continued to talk defensively about himself and his problem. When he found that he was listened to with respect and without criticism, that he was not met by authoritative demands to get out and do something, he began gradually to accept the suggestion that perhaps the first thing to do was to find out what was really wrong with Mrs. J., why she was unable to do even the simplest things in the house - - it was understandable that Mr. J. had to take over, and the worker could see this for himself. On this basis Mr. J. was willing to accept the need for a physical and psychological examination for Mrs. J.; he refused one for himself.

Beginning of Activity. In the meantime he had accepted several other seemingly casual suggestions by the worker. He began to make efforts to provide different and better food for the children, and he took the baby to a doctor who prescribed a change in diet that resulted in Charles beginning to show some changes in growth. When the worker, after a while, picked the baby up and stimulated him, Mr. J. was amazed to see the baby respond by kicking and smiling. He confessed he thought Charles was severely retarded. The baby came out of the crib and on to the floor, where he crawled and got in the way of everyone, but at least he received some attention. Taking the baby to the doctor meant walking two miles each way, but out of the wish to please the worker and because he saw changes in Charles, Mr. J. made a number of such trips.

The result of Mrs. J's examination showed her to be a retarded woman with an I.Q. of about 60; in addition, she was depressed, fearful and anxious as well as having physical symptoms requiring further testing. At first Mr. J. persisted in his belief that she was faking, but gradually accepted the fact that she was ill, and that as much as possible while further testing was done, she needed to be supported and encouraged in whatever few things she could do around the house. So desperate was Mr. J's need for approval from the worker, a hunger not recognized before and a sign of strength in this man, that he was also able to accept gentle direction in having his older children not only begin to take on some chores around the house, but also to help them to be less attacking toward Mrs. J.

Beginning of Control. Meanwhile, when Mr. J. could permit it, there

was much discussion with the school personnel, so that as they knew and participated in evaluating the family situation, their attitudes changed toward the children and some diminution in wild behavior took place.

The combination of some control in the home by Mr. J. and similar control in the school was the new ingredient. Even though Mr. J. was still suspicious of the school, to some extent he could abate his negative collusion with the children against the school and permit the school to institute firm limits. When the children responded positively, his distrust and provocative behavior also lessened.

As Mr. J. increased his trust in the worker, the latter began to talk with him about the loss of control which created such problems for him. Mr. J. began to question why this was so, and then accepted referral for a physical and psychological work-up. The results showed him to have superior intelligence, but his paranoid trends interfered with the use of this good intelligence. Physically, he was in good condition. The clinic spelled out specific treatment objectives, which the worker undertook under the clinic's direction. Gradually Mr. J. began to see that his own feeling of inadequacy made him hit out at other people, with the consequence that he often lost jobs and was not able to put his good mind to effective use.

Such understanding was a slow process, involving much examination of specific incidents, so that Mr. J. could review each one to see what his behavior was really like. He began to sort out his own behavior from that of other people's and to obtain some perspective on the self-destructive nature of his behavior, as well as to develop ideas as to

how it could be altered. For example, he told the worker an incident of sitting on a stool in a neighborhood store, drinking a cup of coffee, when another patron, while looking at a magazine, nudged him a number of times. Mr. J. became very angry and had a fist fight with the man. He felt that he had been nudged deliberately to provoke him. The worker asked if it were possible that the nudging had occurred with no provocative intent while the man was moving through the magazine, and could the argument have been avoided if he had been asked in a friendly tone of voice to be more careful. Mr. J. thought about this for a minute and then replied that he was no pansy. The worker pointed out that many athletes and soldiers who have proven their masculine ability are soft spoken and gentle, that they are not thought of as pansies, and that a man is not a pansy because he does not get into trouble. Could it be that Mr. J. fought because he did not feel sure of himself?

Discussion of similar incidents gradually helped Mr. J. to begin to learn the difference between standing up for himself in a reality situation and fighting because of his feeling of inadequacy. While this was being worked on, changes were occurring with the children. These changes were the result of Mr. J's beginning sense of self-respect, which enabled him to make realistic demands on the children as well as to provide more adequate care for them. The children were better fed and clothed and were not creating problems in the neighborhood by begging or by extreme destructive behavior. Mr. J. could now be firmer with them, setting appropriate controls for behavior without stimulating them to fight in the same way in which he needed to fight. Mrs. J., while greatly limited, was less frightened and depressed and was doing

a few simple things, although Mr. J. was still carrying the major household tasks.

New Aspirations. Mr. J. began to express a wish to go to work, as well as the fear that he could not do so because there would be no one to care for the children. The use of a homemaker was discussed in order to permit Mr. J. to take tests at the Division of Vocational Rehabilitation. He was reluctant to accept this, suspicious that no homemaker could do what he could do for his children. The worker agreed this was probably so, but suggested that it be tried, and if it did not work out, well and good. On this basis Mr. J. accepted the proposal. The plan with the homemaker was carefully worked out in terms of selection of an older, non-threatening woman, and by careful introduction to the total family in order to obviate as many difficulties as possible. Mr. J. was the one who gave her instructions about what to do and what she was to help Mrs. J. do.

The Division of Vocational Rehabilitation found that Mr. J. had excellent potential for a number of skills, from among which drafting was selected, and a plan for training was developed. Because of where the J's lived, transportation was needed and the American Red Cross agreed to provide this for a limited period of time. Mr. J. admitted that he had been driving a friend's car, without a license. He was helped to obtain a license and his friend agreed to lend him the car - - which was ten years old but in running condition - - so that after a short period of help from the Red Cross, Mr. J. could provide his own transportation.

Mr. J. did extremely well in his training, but the plan collapsed after several months when Mrs. J. became seriously ill and had to be hospitalized. A diagnosis of advanced multiple sclerosis was made. The disease progressed very rapidly in its physical and mental manifestations, and presently there is little indication that she will ever return to the home. At the same time the homemaker became ill and it was so difficult to find a replacement that Mr. J. had to stop school to take over the care of the home and children. The old rented house broke down; the heating, plumbing and cesspool went bad. The Department of Welfare could not legally pay for necessary repairs, and it took several months to find a newer house in a public housing development. Eventually a new homemaker was located and Mr. J. returned to drafting school.

His attendance has been excellent. Grades are all A's and B's. The first training period was set for six months. It was decided to re-evaluate his potential after that period in order to determine whether his training would be extended for another year and a half for the full course, which was then underwritten by the Department of Vocational Rehabilitation.

In the most recent months further striking changes have taken place. Mr. J. now feels the need for companionship and friendship. He has discussed his plans to join a church group, and has enrolled the children in Sunday School. He has resumed some contact for himself and his children with his parents, from whom he had been estranged. He now can leave the children briefly with them when the homemaker is not there, while he shops or visits people. He recently inherited \$400 from his grandfather's estate, and would have liked very much to use this for

a better car, but could accept the need to share this resource with the Department of Welfare so that its use was budgeted in a way acceptable to both. The children are in much better shape -- they show some continuing problems in school, but are learning and are well taken care of physically. Mr. J. is a good father and, despite the deprivations the children incurred through the inadequacy of the mother, his love and his ability to manage them are going a long way towards helping them meet normal growth and developmental tasks.

TOOLS REQUIRED TO ACHIEVE GOALS

It is clear that the goals as they were outlined are being achieved. Let us turn now to an examination of what was required in order to achieve these goals. I will discuss these requirements from the point of view of skill, use of time, use of resources, expenditure of money and the place of social values.

Empathy. Before we can consider specific knowledge and skill, there is a basic requirement for working with people in a helping profession. This is the requirement of the kind of empathy which makes it possible to communicate with people from different backgrounds, with different problems. It is a kind of empathy that carries respect for people as they are, and for what they can become. It is not punitive; neither is it maudlin nor sentimental. This kind of empathy is not conveyed by doing things for and to people. Rather, it is conveyed by asking people to do things for themselves by using whatever strengths they have to alter or live better with the life situation. My experience has led me to believe that the largest number of people who choose social welfare as a

profession possess this qualification, and that the requirements of discipline in exercising such empathy come from direct work with people and from discussion of cases with competent personnel in an agency.

If the worker in the J. case had not possessed this quality, he could not know how to approach Mr. J. He could not use one of the basic concepts in social work, that of accepting people where they are and listening, without preconceived judgment, to what is hurting people. To accept does not mean to settle for inadequate or destructive behavior. Instead, it implies awareness that no person really wants to be inadequate, and that difficult and destructive behavior and symptoms are defensive maneuvers used to handle unacceptable feelings and needs. The worker had to listen to Mr. J. before he could understand the facts. Such listening is an active form of participating with clients. It is the basic for establishing a relationship. Without this kind of listening the worker could not help Mr. J. to develop a sense of trust and, in turn, unless trust is developed, nothing therapeutic takes place. Respect for the person means that reality is not disguised or minimized and that what is to be worked on is presented clearly and honestly. Thus in the J. case, the worker did not minimize the seriousness of the situation with Mr. J., he did not promise that the children might not have to be placed, but he did state that he wanted to help with what was hurting.

Let us turn to some of the specific areas of examination I have suggested.

Skill. It is obvious that in order to undertake the kind of

treatment that was so successfully pursued with the J. family, there needs to be knowledge about human development and behavior, not only of the individual but of the total family. There needs to be a dynamic assessment, not only of what is sick and pathological with the individual and family, but, significantly, of what is healthy and potentially healthy. Looking at the J. family from the point of view of pathology alone could not only be overwhelming to anyone viewing it, but could also lead to a premature decision that very little could be achieved. There could be serious question about maintaining the family as a unit.

Certainly it is necessary to understand, without minimizing it, the kind of pathology that exists. We see a man who appears to be unable, both because of personality problems and lack of skill, to hold a job, a man who has no trust in people, who shows paramoid trends, who appears to have little capacity to understand the needs of his wife and his children. Mrs. J. is not only mentally retarded, there is a possibility that she is a borderline personality, one who verges on the psychotic or actually may be psychotic. The children are disorganized, out of control, and give indication of possibly developing the kinds of character problems that often lead to anti-social, delinquent behavior.

If one were to accept this as the totality of the picture, it would be bleak indeed. This viewpoint would indicate a limited understanding of human behavior. What one also needs to know and do is to test for and assess any capacity for strength and potential development. This takes, as I have indicated, empathy, listening, and unbiased observation. When this was patiently and slowly tested with Mr. J., Mr. J's ability to respond to the interest and warmth of another person emerged and he

began to trust and, slowly, to show considerable strength in developing capacity to be aware of how his own behavior contributed heavily to the problems in the family. There also emerged his strong love for his children and his wish to somehow have life better for them. The worker's skill, patience and warmth in recognizing and working with Mr. J's strengths at Mr. J's own pace was one of the most significant factors in the changes that occurred in this family.

The skill was evidenced in the worker's recognition of pathology but on his focus on the healthy aspects. He began with the expressed area of concern, the children, and utilized Mr. J's love for the children to encourage Mr. J. in taking those steps that would benefit the children. This was done at the pace Mr. J. could tolerate, always with full discussion and always with recognition that Mr. J. had to take the steps himself, with the worker paving the way but not taking the steps for Mr. J. The worker recognized that Mr. J. could not, early in the relationship, tolerate any examination of his own contribution to the family's problems, but he could use help in the family's behalf. Only when Mr. J. began to see evidence of the success of his own efforts could he permit any looking at himself. Out of this focus on strengths came Mr. J's ability to look at his wife differently, to permit her to have the care that she required, and to begin to provide some kind of structure for his children, so that they in turn could respond to the setting of the desperately needed controls and limits. Certainly they could not have responded without the basic love that existed between Mr. J. and his children.

In permitting the examination and treatment that Mrs. J. needed,

not only could Mr. J. recognize more sympathetically his wife's problems, but when the time came he could take action toward her hospitalization. This furthered the stability of the family despite the mother's needing to be out of the home permanently. With the father's changed attitude, the children could be helped to view the mother realistically as a sick person and not one who was disinterested and unwilling to care for them. This, as we know, has great meaning to children, who can much more readily accept and understand the reality of illness than a feeling of confusion and anger about a mother's lack of love and care. Such understanding is an aid in the development of necessary internal and external self controls.

Does it require a high degree of professional skill to understand and work with people in this way? I believe that it does. But I also believe that, with competent professional supervision, a worker without special education can undertake even so complicated a case as the J. family presents. The J. case illustrates the need for education in how to approach people, how to learn to listen, how to assemble facts, and how to use a variety of resources appropriately. The clinic, for example, made the clinical diagnosis on Mr. J. and guided the worker in the techniques to be used with him. Certainly if Mr. J. had been on the verge of or in a paranoid psychosis, another kind of treatment with different skills would be required. Much that is vital and rewarding can be accomplished by supervision, consultation and a strong and continuing in-service training program. It is difficult, as we all know, to plunge into dealing with people in trouble without the disciplined point of view, body of knowledge, assortment of skills and understanding of social values that

are essential for effective service. In the J. case, the worker needed to know enough about people to know what resources to use, when to use them effectively, and how to blend them. It seems to me that the public welfare worker was the instrument of choice in this situation because it required a many-pronged, coordinated approach. Had each segment of problem been dealt with alone and in a variety of settings, the result would, I believe, have been failure.

Time. It is, of course, obvious that no matter how skilled the worker is who carries the usual large case load in a public agency, he cannot possibly have the time to work effectively with such a family as the J's unless sufficient time is made available for use by plan. The J's were seen once a week, most often at home since it was very difficult for them to get to the agency. There were times when they were seen more frequently -- for example, nine times during one month, when they needed active direction and support in working out hospital arrangements for Mrs. J., and again during another month when Mr. J. was feeling understandably discouraged about finding and working out housing arrangements. Not only is it important that families who require this service be seen much more frequently than can be afforded in the usual public agency case load, regularity in the use of time is also significant. As we can see, developing in Mr. J. a sense of trust in the worker required both frequency and regularity in the use of time.

Certainly not every family needing assistance from a public agency requires this kind of time investment, but I believe a differential use of time points to the need for constant examination and assessment of case loads in order to sift out those families who do require this much

time and effort so that some provision can be made either for smaller case loads or a more balanced type of case load. Since the time when the J. case was transferred from one division to another, this particular department of public welfare has integrated its separate divisions so that workers carry an undifferentiated case load. I believe this is sound, providing there is recognition of differential needs in a case load for use of skills and time.

The time factor also is significant in another aspect. Progress in the J. family appears slow, yet in the light of understanding the social and personality problems in this family, it was most important that the worker move step by step and not attempt to push the family beyond the point they were ready to go. Had the worker, for example, pushed Mr. J. to work without knowing the reality factors in Mrs. J's illness and the needs of the children, as well as Mr. J's feelings about the children and his attitudes toward the outside world, nothing of successful consequence would have taken place. It is difficult to push people beyond their capacity when contacts are infrequent and limited, and when service is not based on the kind of relationship that takes time and effort to establish. When time is used inappropriately, it leads to frustration, both for the family and worker.

Community Resources. One of the most effective aspects of the work done with the J's was in the appropriate selection, timing and skillful use of various resources within and outside the agency. We can note the competent use of medical, psychiatric and psychological resources, the work with the school, the use of homemaking service, of

the Division of Vocational Rehabilitation, the participation of the American Red Cross. Several aspects are outstanding.

One was the careful, advance preparation that was undertaken with the family and with the resource. There was clear and specific discussion with Mr. J. as to the purpose for using the resource, so that he knew exactly what to do, what to expect, and how he would be met. There was preparation with each resource, so that each could deal with Mr. J. in a way that did not frighten or antagonize him. The school personnel were helped to understand the nature of the problem so that they realized how the pressure they had been putting on Mr. J. increased his resistance and added to the children's difficult behavior. They relaxed until he could begin to make some changes himself with the children and could accept the use of controls by the school.

Each time a resource was used the results were funnelled back to the public agency worker and through him to Mr. J. This was very important, since it was with this worker that Mr. J. had a good working relationship. This made for less confusion for Mr. J., furthered his sense of trust in the worker and aided him in understanding how the various strands meshed together in terms of planning needs for the total family. It furthered his participation and his adequacy. When mistakes were made, as is inevitable, he could discuss his anger and suspicions with one person. Out of this he was better able to tolerate pressure and frustration such as occurred when he had to stop school for a period of months while plans were being developed with regard to Mrs. J's hospitalization and a new homemaker. It aided him in understanding and

accepting the ability and the limits of the public agency in the planning and use of money when he wanted to buy a car.

All too often community resources are used in such a way that a family is sent from one to another without understanding the purpose, without feeling that they themselves have a major responsibility in the utilization of the resource, and without feeling that they have major responsibility for the decisions to be made following the use of the resource. This frequently results in costly expenditures by the community, since people either fail to use the resource or use it inadequately. Certainly it results in costly failures to the family, since it furthers their sense of distrust, antagonizes and makes them unwilling to use what is available to them. Again, not every family needs the kind and degree of preparation that was undertaken with the J's, but every family needs to know why and when the use of a particular resource is indicated, so that they can make choices and decisions. When resources are limited or non-existent, the family needs to know this, too, so that they are not left with a burden for which they cannot be responsible. When the worker adequately considers with a family the use or the lack of a resource, he is not left with a sense of frustration or anger towards the agency and community, an anger that may lead to displacement on the family in harshness or indulgence.

Expenditure of Money. This family was known to the public agency for ten years before the current efforts were undertaken. Those ten years were enormously costly to the community from the point of view of money alone. We can speculate that if a different approach in work had

not been undertaken in 1960, the situation would have deteriorated even further, resulting probably in placement of the children. Looking at it from the use of money alone, placement of children in foster homes or institutions is perhaps the most costly way of dealing with a situation, far more costly in dollars and cents than money used to maintain a family. We can also speculate that Mr. and Mrs. J. would have needed to continue indefinitely, perhaps for a lifetime, receiving public assistance. Although I am sure the cost in money has been high during the current period, and will continue to be so until Mr. J. is employed, I am equally sure that in the long run it will turn out to be far less expensive than maintaining for a great many years a dependent family, either as a family unit or with children in placement.

The willingness and ability of the public agency to invest money in the expenditure of time and effort on the caseworker's part and in the use of the various community resources, resulted, I believe, in less costly service than the amount of previous ten years. Were we to speculate further, knowing as we do now that placement of children should be a last resort only, we could foresee the possibility that a consequence of the placement of the J. children would be that they could become the kinds of persons who, in one way or another, remain indefinitely an expensive burden on the community. We know that in order to grow and develop into reasonably mature adults, children need their own parents, and no foster home or institution - no matter how good - can ever completely handle the feelings of rejection, of guilt, of hostility that children experience when they are placed. This deep sense of rejection and of failure and inadequacy often underlies the too-frequent inability

of children who are placed to make self-responsible, independent adjustments later in life. The serious social and personal maladaptation of many of these people is the cause of heavy community money expenditure. This is not to say that there are not those situations in which there is no choice but placement. There are situations in which basic physical and psychological life are threatened unless a child is removed from his home, but as I have indicated, I believe placement should be used only as a last resort and when all else has failed.

Belief in People. Perhaps I have left the most important thing to the last: that is, the need for all of us to have an unwavering belief in the value of human beings - a belief strengthened by current knowledge that there are very few human beings who do not have some potential for growth, development and self-responsibility, provided they are given opportunities through appropriate nurturing; a belief that it is the job of social welfare and the job of each social worker to find the latent seeds of growth and to provide the climate, the skill, the money, the time and the community resources that will nourish these seeds to the limits of whatever growth capacity exists.

MOBILIZATION OF RESOURCES AND STRENGTHS

I have tried to present via the J. case how the social needs of people can be met through the use of environmental resources when their use is based on adequate knowledge of the total family, its strengths and weaknesses. Helping people to change their life situations for the better through helping them to use the environment differently is, in my opinion, an exacting and gratifying work experience and one that can be

undertaken more effectively by the public welfare worker. The majority of people known to the public welfare agency are not as chronically disturbed as the J. family. Many come when there is a crisis. If they can be helped speedily during the crisis by appropriate mobilization of personal, family and environmental resources, they often can be restored to adequate social functioning. This is true both for people who are basically adequate and for people who have chronic problems that periodically erupt into crises. A relatively short period of concentrated effort and time is of the essence in these situations.

Quick assessment of the core problem confronting these people and quick mobilization of the environmental resources, combined with an approach of respect for people's strengths, is more important than an assessment of the pathology in these situations. In essence the approach is, "Given your situation, what can I help you to do about it right now?" Helping people to move to adequate housing, for example, is more than just a simple act of giving money. It conveys a respect for basic needs that can lift a whole family from feeling that they are worthless to a sense of self-respect that will set in motion new ways of living. I recall a woman saying, when the worker suggested an increased laundry allowance during a period when three small children were ill and bedridden, "I was afraid to ask. Your offering it is the first time I've felt anybody cared about what happened to me." This presumably simple act provided the seeds of far-reaching consequences for this woman and her children.

Some families need money alone, money that is adequate to meet essential living requirements. These are families who can find their own way of meeting the demands of life. When this is done appropriately

it strengthens the family's adequacy. Others may need an approach that, for want of a better term, I am calling a social problem approach, expressed in such needs as mass housing, employment in a depressed area, recreation, etc. Some of these needs may require collaboration with social work, some must be met in other ways. Case finding and selection for which the public welfare worker has responsibility is of the utmost importance if we are to be clear about the use of a variety of approaches, of which social work is one. The greater the degree of clarity in this respect, the greater will be the total community involvement in meeting the problems of human welfare. As a social worker I am convinced that such clarity will also help us to determine more definitely what the public welfare worker can do, and this, in turn, will move in the direction of making the task more productive and enriching for the worker and hence more beneficial to the people he serves.

APPENDIX A

Some Questions and Answers

Question: "Is doing something tangible for a client the best way to establish a positive relationship?"

Mrs. Scherz: "No, I don't think it always has to be done by giving something or providing something. I think families are very different. I think, for example, with the J. family, the giving - to put it in that sense - was initially in the fact that here, at last, was somebody who was willing to listen to this man's complaints without knocking him down, without telling him 'Cut it out, you know, and get off your rear end and do something right away quick.' This was giving, and this was doing something, and this is the way you establish a relationship there - and this was, to me, a real level of communication with this man."

"As was pointed out earlier, often with many middle class families you have a much more intellectual and kind of verbal level of communication. In some families tangible requirement is the thing that is their means of understanding communication. But again there, in the tangible giving, this has to be done realistically and not with the idea that it is being done to so-call establish a relationship. Because if it isn't done realistically the client may see through the false attempt. Our clients are just as smart as we are, and they sense everything that we are up to often better than we do ourselves about ourselves, especially a man like Mr. J., who, believe me, would read this worker's feelings a lot better than many of us ever put together are doing."

"So establishing relationship has many facets to it. Basically, it carries with it a willingness to try to communicate at whatever level or in whatever ways the people that you're dealing with are at, and not on the one level that, unfortunately, in social work in many ways we have clung to for too long - and that is feeling that the only real level of working is on a so-called verbal, intellectual level. These were the prize cases - you know, where you could sit and chat about the neuroses, etc. So I think this other is, again, learning to differentiate what it is people really need and how they communicate, and this is the way you establish a relationship - at least I think so."

Question: "What approach should be taken when community facilities are not available to deal with family needs? For example, during the time no housing could be found for the J. family, or do we assume all needs can be met - a little?"

Mrs. Scherz: "I suppose, in a real sense, need is infinite, and it can't be met, and that, everybody, somewhere in this life, has to face up to -- that he can neither get his own needs met in any infinite sense nor can he meet anybody else's -- and resources are never going to exist that are going to meet need of any kind in any total sense, in any coverage sense.

"Certainly every one of us tears our hair out all the time over gross needs that aren't met and that aren't socially available. I suppose there again, partly, social work can't just take it upon itself to think that this is the only profession that has to set out to do this. For example, being unable to meet housing is not just the responsibility of social workers as a profession. It's the responsibility of the total community, and much more, in the way of working together cooperatively in a variety of ways to meet needs of that kind.

"However, if you don't have these facilities (and I don't know any community that does; I don't care how rich a community is in resources, it's just never enough and probably never will be) often, of course -- and I am not being Pollyannish about it -- there are some second best things to do. But even when those don't exist, it seems to me one has to honestly face this with the clients we are dealing with. Because if you don't, as I think I have tried to indicate, you leave them with a burden that they are not responsible for, and it does something to yourself too. At least if you can face it honestly together, this has some meaning and some real value for people, even if you're not able then to provide what it is they really should have."

Question: "Is decrease of family size typical of all classes?"

Dr. Parsons: "There are two meanings of decrease of family size that, I think, should be distinguished. One, of course, is number of children per nuclear family, and the other is what census people call a household, which is the people sharing a common household, whether they are members of the same nuclear family or not. The long-run trend has been decreasing in both respects, with the increase in the first sense since about 1940. But it is true, also, that this increase has been accompanied by a homogenization; that is, there is a very much smaller number of very large families than there used to be, even five, certainly six or more children, and there is a smaller number of childless couples who have been married for considerable periods, and of one, particularly one, child, but even two child families; that is, it's squeezed in toward the modal area of the three, or two to four, but three is perhaps the modal number of children."

Question: "Do you believe there is a sufficient difference in goals and values of the lower class group so as to block communication with social workers, or do we assume a similarity of basic goals and values?"

Dr. Parsons: "I think my two colleagues have given the basic material in answer to that, particularly Mrs. Scherz.

"I think that what I call the lower class status is a very serious barrier, and it is a barrier that the common sense of the helping professions has, to a large extent, proved to be incapable of getting over. I think it requires special understanding. The one side of it was Mrs. Scherz' point about willingness to listen, to try to understand without value judgments or suggested action. The other side, that is terribly important, is to see the possibilities of potentials for growth. My own view would be that it is deeply engrained in the values of our society that there is no inherently inferior group... I say 'group.' There are, of course, mentally retarded individuals who simply cannot be brought to a normal level of performance, although probably progress in these areas is hopeful. I mean the social group in the more general sense. I think there is no inherently inferior group, and, therefore, the potential that Mrs. Scherz referred to is to be found if only there is the patience and the insight to find it and to use the resources to develop it, really to give it an opportunity to develop, because I think the point about the tremendous importance of the individual's performance is one of the most important points to be made."

Question: "As social workers deal with tangible problems - income, housing, etc. - are mental aspects of the problems resolved, or should we seek to become more aware of family mental health needs as an end in itself?"

Dr. Rogawski: "I think that I answered this question in my speech this morning when I said that every activity has various aspects; that something that, in fact, is an action help may indeed also affect the emotional climate in a situation, in a relationship, in the family, and vice versa. You cannot really separate these two aspects. I think they are various faces of the same problem."

"I would like to take this opportunity to say something regarding Mrs. Scherz' presentation that reminded me of something that we have frequently done in our Mental Health conferences. When we looked for - well, I used their own word for it, and I am still looking for a good word - I used the words 'a weak point in the defensive structure' - when we tried to find out where we can reach a person. Now here, in the case presented by Mrs. Scherz, I believe that the important turning point was that the worker realized that there was a tremendous investment in Mr. J's children; that was a motive for going on, for doing something, and that one could reach him over these children by uniting forces with him. This, for instance, is one way of establishing rapport - to recognize where (or how) in this whole defensive structure, when you literally touch him in the store and he explodes in a fist fight, you can get by those fists. Well, you can see that better when you step back a little while and just listen and look for it with your radar system that you have between your ears. You look for the fulcrum where you can put in your lever, and when you have found that point, then I think both aspects, the realistic and the mental health aspect, can be approached."

APPENDIX B

GENERAL SESSIONS

January 8-9, 1964

Jean Delacour Auditorium
Los Angeles County Museum
900 Exposition Blvd.
Los Angeles

9:00 - 9:30 Welcome

Ellis P. Murphy, Director
Los Angeles County
Bureau of Public Assistance

Introductions

Frances Lomas Feldman, Associate Professor
School of Social Work
University of Southern California

9:30 - 10:30 The Normal Family

Dr. Talcott Parsons, Professor
Department of Social Relations
Harvard University

10:30 - 10:45 Refreshments

10:45 - 11:45 Helping Families in Crisis

Dr. Alexander Rogawski, Consultant
Los Angeles County Department
of Mental Health

11:45 - 1:00 Luncheon

1:00 - 2:00 Social Needs of the Welfare Family

Frances H. Scherz, Director of Casework
Chicago Jewish Family and
Community Service

2:00 - 3:00 Question and Answer Period

APPENDIX C

Workshop Leaders *

Mrs. Dorothy Blair	Miss Beverly McComic
Mr. Joseph Cherry	Mrs. Ellouise Minter
Mrs. Annette Crowell	Miss Elizabeth Shapiro
Miss S. Ellen Henderson	Miss Mary Sullivan
Mrs. Dora McAfee	Miss Vehanoush Zakarian

Workshop Resource Experts **

Miss Mary Lou Clark	Mr. Harry Schonfeld
Miss Lois Fletcher	Mr. Gordon Smith
Mrs. Mary Alice Kahne	Mrs. Florence Stollern
Mrs. Mabel Kamp	Mr. Samuel Taylor
Miss Ruth Kukkonen	Miss Eve Vieregge
Mr. George Richey	Mrs. Joyce Wills
Miss Helen Savran	Mrs. Mary Winters

* Training Supervisors, Los Angeles County Bureau of Public Assistance

** Psychiatric Casework Specialists and Supervisors in the California State Department of Mental Hygiene

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